Headquarters U.S. Air Force

Integrity - Service - Excellence

Evaluation and Management Coding

Taking Credit for What You Do

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Feb 04

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Evaluation and Management (E&M)

Objectives

- Recognize the purpose of CPT E&M coding
- Define the difference between new and established patient; between referral and consult
- List components in identifying the correct code
- Identify the 3 key components of E&M Level of Service Codes
- Recognize when to use E&M modifiers and quantity
- Recognize coding situations unique to the MHS

Bottom Line:

Even if you don't actually code–

You need to know what to document to have the coder give you credit for what you did

ADM Patient Encounter

ANT,ADAM 20/806-51-0101 AGE:51y

Appt Date/Time : 28 Jun 2003@1600 Type: ROUT Status: KEPT

Clinic: GENERAL SURGERY SAME DAY SURGERY MEPRS : BBA5

In/Outpatient: Outpatient APV: Yes Work Related: No

Appt Provider: BUNNY,EASTER Injury Date :

2nd Provider #1: CHICKEN,SPRING Role: ASSISTING

2nd Provider #2: Role:

Disposition: RELEASED W/ WORK DUTY LIMITATIONS

==========

ICD-9 Dx Description Priority

\+ 401.0 MALIGNANT HYPERTENSION 3

305.1 TOBACCO USE DISORDER U

250.60 DIABETES W NEULOL MANIF UNSPEC 4

278.01 MORBID OBESITY 2

Chief Complaint: 540.9 ACUTE APPENDICITIS NOS

ADM Patient Encounter - E&M Code Enter/Edit

ANT,ADAM 20/806-51-0101 AGE:51y

Appt Date/Time : 28 Jun 2003@1600 Type: ROUT Status: KEPT

Clinic: GENERAL SURGERY SAME DAY SURGERY MEPRS : BBA5

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ICD-9 Dx Description Priority

540.9 ACUTE APPENDICITIS NOS 1

278.01 MORBID OBESITY 2

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250.60 DIABETES W NEULOL MANIF UNSPEC 4

========== Dx Lvl ==========

E&M Code Description (Maximum of 3 codes) 1-4 Mod1 Mod2 Mod3 Units

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99499 UNLISTED EVALUATION AND MANAGEMENT SERVICE 1 1

Edit Icd-9 e&M Cpt/hcpcs Admin Code File View mail cUo eXit

ADM Patient Encounter - CPT/HCPCS Code Enter/Edit

ANT,ADAM 20/806-51-0101 AGE:51y

Appt Date/Time : 28 Jun 2003.@1600 Type: ROUT Status: KEPT

Clinic: GENERAL SURGERY SAME DAY SURGERY MEPRS : BBA5

==========

ICD-9	Dx Description	Priority
540.9	ACUTE APPENDICITIS NOS	1
278.01	MORBID OBESITY	2
401.0	MALIGNANT HYPERTENSION	3
250.60	DIABETES W NEULOL MANIF UNSPEC	4

========== Dx Lvl ==========

CPT/HCPCS	Description	1-4	Mod1	Mod2	Mod3	Units
44970	LAPAROSCOPY, APPENDECTOMY	1				1

ADM Patient Encounter

ANT,ADAM 20/806-51-0101 AGE:51y

Appt Date/Time : 28 Jun 2003@1600 Type: ROUT Status: KEPT

Clinic: ANESTHESIA MEPRS : DFAA

In/Outpatient: Outpatient APV: Yes Work Related: No

Appt Provider: CLAUS,SANTA Injury Date :

2nd Provider #1: HOG,GROUND Role: CRNA

2nd Provider #2: Role:

Disposition: RELEASED W/ WORK DUTY LIMITATIONS

Proposal for Anesthesia Collection

1. MEPRS DFAA
2. Separate SADR
3. Anesthesiologist as attending, CRNA as assisting
4. Units = minutes
5. Code anesthetic, but not pain medications

==========

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278.01 MORBID OBESITY 2

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Edit Icd-9 e&M Cpt/hcpcs Admin Code File View mail cUo eXit

ADM Patient Encounter - CPT/HCPCS Code Enter/Edit

ANT,ADAM 20/806-51-0101 AGE:51y

Appt Date/Time : 28 Jun 2003.@1600 Type: ROUT Status: KEPT

Clinic: ANESTHESIA MEPRS :DFAA

Proposal for Anesthesia Collection

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278.01	MORBID OBESITY	2
401.0	MALIGNANT HYPERTENSION	3
250.60	DIABETES W NEULOL MANIF UNSPEC	4

========== Dx Lvl ==========

CPT/HCPCS	Description	1-4	Mod1	Mod2	Mod3	Units
00840	ANESTH,INTRAPERITONEAL L ABDOM:NOS	1	QK			123
00840	ANESTH,INTRAPERITONEAL L ABDOM:NOS	1	QX			146
J2250	INJ MIDAZOLAM HYDROCHLORIDE	1				20

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Why do we need accuracy?

- Ensures providers/facility receives proper credit for level of effort expended
  - Current MTF budget proposal based on
    - Empanelled population
    - Fee for service for non-enrolled
    - Readiness
- To predict the future
- Billing

What may we code?

- Code **ONLY** what is documented
- Need legible, complete documentation

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Current Procedural Terminology (CPT)

- Written by Am Medical Assoc as way to request reimbursement from payors
  - Updated annually
  - Read “physician” as “privileged provider”
- Provides uniform language
  - Most widely accepted nomenclature for visits
- Explain what services were performed
- Must be supported by ICD-9-CM codes

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Privileged or Non-Privileged

- Privileged providers:
  - May use all E/M codes
  - Use 99499 if no E/M for the encounter
- Non-privileged providers:
  - Use 99211 if encounter w/o procedure
  - Use 99499 if encounter w/procedure
- Use For Clinic Use Only to collect types and times

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New vs Established

- New - not received care in your group practice (clinic) in 3 years
- Established - received care in your group within the past 3 years (if seen first as an inpatient as in the case of infants, the inpatient care would be the “new” and all other care “established”)
- Train your tech to ask patients if they have been seen in your clinic before, and have the tech document it

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How to select the correct code

- Setting (e.g., clinic, ER, telephone, same-day-surgery, observation, inpatient, nursing home, group)
- Patient type (e.g., new/established, age)
- Level of service (e.g., problem focused, simple)
- Length of time (e.g., prolonged, wellness class)

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Setting - outpatient

- Office Visit
  - New - 99201-99205
  - Established 99211-99215
- Observation 99217-99220
- Consultation (New or Established)
  - Outpatient 99241-5
  - Inpatient 99251-5
- Emergency Services (New or Established) 99281-5
- Prolonged Services (w/face-to-face and w/o face-to-face) 99354/5, 99358/9
- Telephone calls 99371-3

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Setting - outpatient

- Preventive Medicine Services 99381-99412
  - Initial Preventive Medicine (physicals), based on age 99381-7
  - Periodic Preventive Medicine (physicals), based on age 99391-7
- Individual Counseling 99401-4
- Group Counseling 99411-2
- Work Related or Medical Disability Exam 99455-99456 (Return to Duty)

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Setting - inpatient

- Hospital Care – Initial 99221-99223
- Subsequent 99231-99233
- Admit/Discharge Same Day 99234-99236
- Discharge 99238-99239
- Neonatal and Pediatric Critical Care 99293-99299

Setting – No E/M

- 99499 – Unlisted E&M
  - Use for same-day-surgery
  - Use for group education (e.g., prenatal, tobacco cessation)
  - Use for mental health therapy
  - Use for optometry
  - Use for OT and PT
  - Use for audiology
  - Use for allergy
  - Use for reading EKGs
  - Use for interpretation of videotaped telemedicine
  - Use for anesthesiology…

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Counseling vs Education

- Counseling/Prevention/Risk Factor Reduction - before there are symptoms, a condition or established illness - counts as a separate prevention visit, does not need history, exam, or decision making

- Education - after there are symptoms, a condition or established illness

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Consult vs Referral

- Consult - before a diagnosis is made and treatment begins - a consult could be a series of visits - “Evaluate and return”

- Referral - a new or established office visit - “Evaluate and treat”

Level of Service - Clinic Visit

- Visit documentation has 3 main parts
  - History (Subjective)
  - Exam (Objective)
  - Decision Making/Risk (Assessment, Plan)
  - time is not usually a factor

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Subjective

- Patient History
  - Chief Complaint
  - History of Present Illness
  - Review of Systems
  - Past/Family/Social History

  - Note: even though B/P, temp, pulse, height, weight are taken at the same time the subjective data is collected, those are part of the exam (objective)

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History - Chief Complaint

- Concise statement describing the symptom, problem, condition, diagnosis, physician recommended return, or other factor that is the reason for the encounter, usually stated in the patient's own words.

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History of Present Illness

(possibly use pain evaluation factors)

- **O** - Onset
- **P** - Palliative/Provocative - Moderating Factors
- **Q** - Quality (throbbing, stabbing, dull, sharp)
- **R** - Radiating (usually reserved for pain only)
- **S** - Severity (scale of 1-10 with 10 passing kidney stone)
- **T** - Timing, when during day, duration
- **Location**
- **Context**
- **Associated Signs and Symptoms**

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History - Review of Systems

- Allergic/Immunologic
- Cardiovascular
- Constitutional e.g., fever, weight loss
- Ears, Nose, Mouth, Throat
- Endocrine
- Eyes
- Gastrointestinal
- Genitourinary
- Hematological/ Lymphatic
- Integumentary (skin and/or breast)
- Musculoskeletal
- Neurological
- Psychiatric
- Respiratory

Past, Family and /or Social History

- Past Patient History
- Family History
- Social History

- usually coded with V-codes

- usually not documented in this manner - expect to see PMHx (past medical history), PSHx (past surgical history), social history (EtOH, tobacco, drugs, student [will need bus waiver], new to base…)

Hint

- Can be documented by:
  - Form completed by patient (e.g., physicals)
  - Medical technicians
  - Provider must acknowledge he/she reviewed it (not just initials, pretty explicit “Reviewed with pt, correct”)
  - If the history on the summary sheet is correct, you can document “see summary sheet” – but the summary sheet needs to be kept current
  - If you are doing rounds, and there has not been a change in the history, document something like “no change in hx from H&P”

Objective - Examination

(12 different sets, depends on type of exam)

- General Multi-system
- Cardiovascular
- Ears, Nose, Mouth, and Throat
- Eyes
- Genitourinary (Female)
- Genitourinary (Male)
- Hematologic/ Lymphatic/ Immunologic
- Musculoskeletal
- Neurological
- Psychiatric
- Respiratory
- Skin

There are CMS 1995 E/M standards and CMS 1997 E/M standards. The AF codes to the 1997. The 1995 did not accurately reflect specialty care. When push comes to shove, there is no statistical difference between the two, which is why they are working on a new standard.

General Multi-system Exam (Objective)

- Constitutional
  - Vital Signs
  - Appearance
- Gastrointestinal
- ENMT
- Cardiovascular
- Respiratory
- Skin
- Lymphatic
- Neurological
- Eyes
- Genitourinary
- Musculoskeletal
- Psychiatric
- Neck
- Chest/Breast

Each system has “bullets”, such as Cardiovascular –
 Palpation heart; Auscultation heart; Carotid Arteries;
Abdominal Aorta; Femoral Arteries; Pedal Pulses
Extremities

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Assessment - Medical Decision Making

- Medical Decision Making includes:
  - Number of diagnoses or management options,
    - This is why it is important to document underlying conditions, co-morbidities; 2 stable chronic illnesses (HTN and obesity) get you a moderate complexity
  - Amount and/or complexity of data to be reviewed, and
  - Risk of complications/morbidity and/or mortality.

Plan - Risk

- Risk of significant complications, morbidity, and/or mortality is based on risks associated with:
  - Presenting problem(s):
    - Chief complaint, HPI, and ROS;
  - Diagnostic procedure(s):
    - Diagnostic data ordered or reviewed;
  - Possible management options:
    - Management options selected or suggested.

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Risk - Plan

- Minimal - one self-limited or minor problem (e.g., cold, insect bite)
- Low - 2 or more self-limited or minor problems OR 1 stable chronic illness OR Acute uncomplicated illness or injury
- Moderate - chronic illness w/exacerbation
- High - pose threat to life or bodily function

New Office and Consult – Need All 3 Components

(approx min is red)

Office, New	**99201-10**	**99202-20**	**99203-30**	**99204-45**	**99205-60**
Consult, OP	**99241-15**	**99242-30**	**99243-40**	**99244-60**	**99245-80**
History	**Problem Focused**	**Expanded Problem Focused**	**Detailed**	**Compre-hensive**	**Compre-hensive**
Exam	**Problem Focused**	**Expanded Problem Focused**	**Detailed**	**Compre-hensive**	**Compre-hensive**
Decision Making	**Straight Forward**	**Straight Forward**	**Low**	**Moderate**	**High Complex**

Established Office– Need 2 of 3 Components

Office, Establish	99211-5 Nurse/ Tech	99212-10	99213-15	99214-25	99215-40
History	Not Required	Problem Focused	Expanded Problem Focused	Detailed	Compre-hensive
Exam	Not Required	Problem Focused	Expanded Problem Focused	Detailed	Compre-hensive
Decision Making	Not Required	Straight Forwar	Low	Moderate	High Complex

Family Practice Clinic **82 Medical Group/SGOMF**
Sheppard AFB, TX

DATE: **TIME:**

S: ___ y.o. female, who is older than 12` y.o., complains of abnormal VAGINAL DISCHARGE for _____ days.
Pain: O/P/Q/R/S/T?
Yes / No Pregnant? First day of last menstrual period _____.
Yes / No Abdominal discomfort?
Yes / No Possibility of sexually transmitted diseases?
Yes / No Could there be a foreign body present?
Yes / No Is the discharge thick, white, and itchy?
Yes / No Is the discharge discolored and/or foul smelling?

O: General
Vulva: Normal Erythema Edema Atrophic Excoriated
BUS: Normal (without discharge or lesion) Discharge Bartholin Cyst
Vagina: Normal Regated Atrophic Discharge
Cervix: Normal Friable Discharge Cervical motion tenderness
Uterus: NSSC Nontender Mobile Tender
Adnexa: Normal Absent Tender Masses Thickened

Lab: KOH fungal elements Within Normal Limits
Normal Saline pH _____ Clue cells Trichomonas Bacteria WBC Within Normal Limits

A: ____ Bacterial Vaginosis (code also organism if known) (616.10)
____ Candidal/Moniliasis (112.1) ____ Trichomoniasis (131.01)
____ Vaginosis in other disease (616.11)
other: _____

Family Practice Clinic **82 Medical Group/SGOMF** **Sheppard AFB, TX**

DATE: **TIME:**

S: ____ year old male / female complains of left / right ANKLE PAIN for _____ days.
Mechanism of action:
O/P/Q/R/S/T?

Yes / No X-ray ordered per OTTAWA RULES For Ordering Ankle X-ray On Reverse

O: General
Right / Left Ankle – benign edematous red ecchymosis
tender where _____ nontender

ROM: FROM decreased
Ligaments - intact +/ - drawer
Neuro - intact deficits
Vascular - Posterior tibial Dorsalis pedis
X-rays / Lab –

A: Left / Right ankle sprain: ___ unspecified (845.00) ___ Deltoid (845.01) ___ Calcaneofibular (845.02)
___ Tibiofibular (845.03) ___ Achilles tendon (845.09)
___ Left / Right ankle fracture (824.9)

E&M Modifiers

- 21 Prolonged E&M Svs
- 24 Unrelated E&M by same provider during post op period
- 25 Significant, separately identifiable E&M by same provider on same day of procedure or other service
  - Use if you do an office visit and that causes you to identify a need to do a “global” 0 or 10 day procedure that same day (e.g., remove ingrowing nail, remove skin tags)
- 32 Mandated service (e.g., required by insurance)
- 57 Decision for surgery
  - Use if you do an office visit that causes you to identify and do a “global” 90 day procedure that same day (e.g., fx, ectopic pregnancy)

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E&M Quantity

- Usually only used with
- 99355 Prolonged physician service in the office or other outpatient setting requiring direct (face-to-face) patient contact beyond the usual service; each additional 30 minutes
- 99292 Critical care; each additional 30 minutes

- Some others, very uncommon –
- 99290 Critical care transport of child less than 24 months, each additional 30 min

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Manning/Bid Price Adjustment

- Great news!! This is becoming less of a player as the T-Nex contracts come on board

- Visit “Count” vs Encounter “Non-count”
  - provider/patient interaction
  - independent medical judgment
  - documented
  - chance to change course of care
- Avoid paying managed care contractor for work you do

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Third Party Collections

- Outpatient claims submitted based on coding
- If you have a nurse/tech/coder coding, need to have provider certify that codes are correct
- Recommend have a good coder re-code documentation before submitting claim until you are sure your coding is excellent
- Residents
- Medical Students

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Optimize vs Maximize

- Optimize coding
  - Annotate everything you do, code what is documented
  - Make sure your providers/coders know everything that can be coded
- Do not maximize coding
  - Do what is necessary, do not do something not medically indicated just to get paid (e.g., if only caps which qualify for reimbursement are stainless steel, but other, less resource intensive methods could work, use the less resource intensive)
- Code correctly - it will lead you to optimizing coding

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Review of E&M Goals

Provide basic coding guidelines to enable providers/nurses/technicians/coders to:

- Be aware of various CPT Evaluation and Management (E/M) code
- What is needed to accurately reflect care provided in the outpatient visit setting
- Basic understanding of documentation requirements for assigning the E/M code for each encounter

Evaluation and Management (E&M) Objectives

- Recognize the purpose of CPT E&M coding
- Define the difference between new and established patient; between referral and consult
- List components in identifying the correct code
- Identify the 3 key components of E&M Level of Service Codes
- Recognize when to use E&M modifiers and quantity
- Recognize coding situations unique to the MHS

I Love to Code!

The Dr. Seuss Collection

The Lost Poem

(Flea I be. I be Flea.)
That Flea-I-be, that Flea-I-be!
I do not like that Flea-I-be.
Would you like to code with me?
I would not like to code with ye!

Would you code charts for your boss?
Would you code at any cost?
I would not code charts for my boss, I would not code at any cost!
I will not code my charts today; please Flea-I-be, please go away!

Would you code for CPGs?
Would you code for TPCs?
Would you code for Uncle Sam?
(That anthrax genie's on the lam!)
I will not code for CPGs, I will not code for TPCs.
Public health is not much fun, the only "n" I know is one!
I will not code charts for my boss, I will not code at any cost.
I will not code for my hard work, please leave me be, I'll be a jerk.

Would you code for RVUs? Would you, could you? You can't lose!
I will not code for RVUs, this coding stuff is just old news!
I will not code for CPGs, I will not code for TPCs.
I will not code charts for my boss, I will not code at any cost
I will not code for my hard work, I will not change, you stinking clerk!

Try it, Try it! Here's the fix! With RVUs, you'll reach two-six!
And when you cross that fabled mark, We'll call off the dogs, the wolves, the shark!
We'll count your work, you will see; the consults, treadmills, EKGs!
The Holters and the cardiolites! We'll count it all – there'll be no fights!

- **And what will all this counting show?**
- **We'll keep your panels at 5-oh-oh!**
- **And seven-fifty will be all, if you're in a clinic small.**
- **So use your pick-lists, old and new, and get your beans where beans are due!**

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Future Talks

- March – CPT Procedures
- April – HCPCS
- May – ICD-9-CM
- June – Business of Coding (CPT and HCPCS)
- July – Aggregate Audits
- August – Documentation
- September – Super Bills
- October – Using Clinical Data (ICD-9-CM)

- Talks subject to change

Questions?

- E-mail your service POC:
  - Lazo, Cielito V. GS BUMED [CVLazo@US.MED.NAVY.MIL]
  - Zoblosky Shirley M Civ AFMOA/SGZZ [Shirley.Zoblosky@brooks.af.mil]
  - Garza Alicia C Civ AFMOA/SGZZ [Alicia.Garza@brooks.af.mil]
  - Army – e-mail PASBA coding help desk
- Or e-mail jeanne.yoder@pentagon.af.mil